

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445512	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED R 05/24/2019
NAME OF PROVIDER OR SUPPLIER NASHVILLE CENTER FOR REHABILITATION AND HEALING LL			STREET ADDRESS, CITY, STATE, ZIP CODE 832 WEDGEWOOD AVENUE NASHVILLE, TN 37203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS During the follow up survey conducted on 05/24/2019 all previously cited deficiencies had been corrected.	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC#2

45th day / 70th
6-8-19 / 7-3-19

The preparation, submission, and implementation of the Plan of Corrections does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all state and federal regulatory requirements. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

K 211 - SS = D Means of Egress – General NFPA 101:

1. Corrective action(s) accomplished for those residents found to have been affected by the finding:
 - A. Pallets and wood post located near dumpster were removed on 4/22/2019 by the Director of Maintenance.
 - B. Education on proper placement of discarded pallets and walkways in general was conducted with the maintenance staff on 4/23/19, by SDC Ongoing education to be completed by 6/3/19 by SDC.
2. Identify other residents who have the potential to be affected by the same finding and what corrective action taken:
 - A. Audit of other exterior pathways completed on 4/23/19, by Maintenance Director. No other areas were identified with egress obstruction.
3. Measures/systematic changes put in place to ensure that the finding does not reoccur:
 - A. Maintenance staff were in-serviced 4/23/19 on the requirements of means of egress by SDC. All other indicated staff receiving in – service by Staff Development Coordinator and Maintenance Director.
 - B. Maintenance painted an indicated area for the temporary storage of pallets and post that complies with egress requirements, to be used as indicated.
4. Monitoring of corrective action to ensure the effectiveness of the education
 - A. Maintenance Director will review the exterior egress pathways Monday thru Friday for 8 weeks (weekends reviewed Monday) and review findings with Safety Committee.
 - B. Findings will be reported to the, ED who will take appropriate action if needed.

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- C. Failure to adhere to facility requirement will result in re-education
- D. Report of findings will be reported to the facility Quality Assurance Committee (QAPI) for a period of 8 weeks to review the need for continued intervention or amendment of plan- team includes: DON, ED, Dietary, Therapy, MDS, Housekeeping, Plant ops. (all department leaders)

5. COMPLETION DATE 6/3/2019

K 324 - SS = D Cooking Facilities –NFPA 101:

1. Corrective action(s) accomplished for those residents found to have been affected by the finding:
 - A. Fryer was re-centered under the hood suppression nozzle on 4/23/2019 by the Director of Maintenance.
 - B. Fryer was tethered to wall on 4/23/2019 by the Director of Maintenance.
 - C. Education on proper placement of kitchen equipment was conducted with the dietary staff on 4/23/19, by Maintenance Director, remaining staff education to be completed by 6/3/19 by Maintenance Director or Dietary Director.
2. Identify other residents who have the potential to be affected by the same finding and what corrective action taken:
 - A. Audit of other kitchen equipment completed on 4/23/19, by Maintenance Director. No other equipment issues were identified.
3. Measures/systematic changes put in place to ensure that the finding does not reoccur:
 - A. Dietary staff in-serviced 4/23/19 on the requirements of equipment placement and tethering by the Maintenance Director. Remaining dietary staff will be in serviced by Dietary Director with full in servicing to be completed by 5/13/2019.
 - B. Maintenance adhered tracks to ensure ongoing compliance with placement of equipment is only as indicated.
4. Monitoring of corrective action to ensure the effectiveness of the education
 - A. Maintenance Director will review the kitchen equipment for placement under hood suppression nozzle and tethering as appropriate Monday thru Friday for 8 weeks (weekends reviewed Monday) and review findings with Safety Committee.
 - B. Findings will be reported to the, ED who will take appropriate action if needed.

- C. Failure to adhere to facility requirement will result in re-education
- D. Report of findings will be reported to the facility Quality Assurance Committee (QAPI) for a period of 8 weeks to review the need for continued intervention or amendment of plan- team includes: DON,ED, Dietary, Therapy, MDS, Housekeeping, Plant ops. (all department leaders)

5. COMPLETION DATE 6/3/2019

K 353 - SS = D Sprinkler System –Maintenance and Testing - NFPA 101:

1. Corrective action(s) accomplished for those residents found to have been affected by the finding:
 - A. Kitchen walk in freezer sprinkler head was fitted with appropriate guard on 5/2/2019 by the Director of Maintenance.
 - B. Education on sprinkler head protection requirements was conducted with the maintenance staff on 5/2/19, by Maintenance Director.
2. Identify other residents who have the potential to be affected by the same finding and what corrective action taken:
 - A. Audit of other sprinkler heads completed on 4/25/19, by Maintenance Director. No other equipment issues were identified.
3. Measures/systematic changes put in place to ensure that the finding does not reoccur:
 - A. Maintenance staff in-serviced 5/2/19 on the requirements of sprinkler head maintenance and review by the Maintenance Director.
4. Monitoring of corrective action to ensure the effectiveness of the education
 - A. Maintenance Director will review sprinkler heads to ensure proper guards are in place as appropriate Monday thru Friday for 4 weeks (weekends reviewed Monday) and review findings with Safety Committee.
 - B. Findings will be reported to the, ED who will take appropriate action if needed.
 - C. Failure to adhere to facility requirement will result in re-education
 - D. Report of findings will be reported to the facility Quality Assurance Committee (QAPI) for a period of 8 weeks to review the need for continued intervention or amendment of plan- team includes: DON,ED, Dietary, Therapy, MDS, Housekeeping, Plant ops. (all department leaders)

K 521 - SS = D**HVAC -NFPA 101:**

1. Corrective action(s) accomplished for those residents found to have been affected by the finding:
 - A. Four Year Fire/ Smoke Damper test was completed on 4/29/19, by contract services.
2. Identify other residents who have the potential to be affected by the same finding and what corrective action taken:
 - A. Audit of other required testing completed on 4/25/19, by Maintenance Director. No other required testing was identified as being due.
3. Measures/systematic changes put in place to ensure that the finding does not reoccur:
 - A. Maintenance staff in-serviced 5/2/19 on the requirements of ensuring required testing be completed within timeframes by the Maintenance Director.
4. Monitoring of corrective action to ensure the effectiveness of the education
 - A. Maintenance Director will review and track all required testing in audit tool weekly for 8 weeks and review findings with Safety Committee.
 - B. Findings will be reported to the, ED who will take appropriate action if needed.
 - C. Failure to adhere to facility requirement will result in re-education
 - D. Report of findings will be reported to the facility Quality Assurance Committee (QAPI) for a period of 8 weeks to review the need for continued intervention or amendment of plan- team includes: DON,ED, Dietary, Therapy, MDS, Housekeeping, Plant ops. (all department leaders)
5. COMPLETION DATE 6/3/2019

K 741 - SS = D**Smoking Regulations –NFPA 101:**

1. Corrective action(s) accomplished for those residents found to have been affected by the finding:
 - A. Cigarette butts located on exterior of building removed on 4/22/19, by Maintenance staff.
 - B. Education on smoking policy was conducted with the facility staff on 4/24/19, by SDC.
2. Identify other residents who have the potential to be affected by the same finding and what corrective action taken:
 - A. Audit of other exterior areas completed on 4/22/19, by Maintenance Director. No other areas identified as having cigarette butts.
3. Measures/systematic changes put in place to ensure that the finding does not reoccur:
 - A. Facility staff in-serviced 4/24/19 on the smoking policy by the SDC and Maintenance Director. Remaining facility staff to be re-educated by 6/3/19 by SDC.
 - B. Additional signage placed indicating no smoking on 5/2/2019 in areas where smoking is prohibited.
4. Monitoring of corrective action to ensure the effectiveness of the education
 - A. Maintenance Director will review exterior areas to ensure cigarette butts are not improperly discarded Monday thru Friday for 8 weeks (weekends reviewed Monday) and review findings with Safety Committee.
 - B. Findings will be reported to the, ED who will take appropriate action if needed.
 - C. Failure to adhere to facility requirement will result in re-education
 - D. Report of findings will be reported to the facility Quality Assurance Committee (QAPI) for a period of 8 weeks to review the need for continued intervention or amendment of plan- team includes: DON,ED, Dietary, Therapy, MDS, Housekeeping, Plant ops. (all department leaders)
5. COMPLETION DATE 6/3/2019

K 761 - SS = D**Maintenance, Inspection & Testing – Doors - NFPA 101:**

1. Corrective action(s) accomplished for those residents found to have been affected by the finding:
 - A. Door gap identified in the bottom of a door entering Laundry of over $\frac{3}{4}$ of an inch will be resolved with a threshold that was ordered on 4/25/19, by Maintenance staff.
 - B. Door wedged open in kitchen storage was resolved by removing wedge on 4/22/2019, by Maintenance staff.
 - C. Door gap identified in the bottom of a door entering Therapy room on 600 hall with gap of over $\frac{3}{4}$ of an inch will be resolved with a threshold that was ordered on 4/25/19, by Maintenance staff.
 - D. Resident bed identified in room 515 to be preventing the closure of the door was resolved on 4/22/2019 by repositioning the bed and residents use of the room, by nursing staff and maintenance staff.
2. Identify other residents who have the potential to be affected by the same finding and what corrective action taken:
 - A. Audit of facility doors conducted by maintenance staff on 4/23/2019. No other doors identified in need of repair.
 - B. Audit of facility doors conducted by maintenance staff on 4/23/2019. No other doors identified as wedged open.
 - C. Audit of facility doors conducted by maintenance staff on 4/23/2019. No other doors identified in need of repair.
 - D. Audit of resident rooms conducted by maintenance staff on 4/23/2019. No other rooms identified in need of repositioning to ensure door closure.
3. Measures/systematic changes put in place to ensure that the finding does not reoccur:
 - A. Facility staff in-serviced 4/24/19 on door closure requirements by the SDC and Maintenance Director. Remaining facility staff to be re-educated by 6/3/19 by SDC.
 - B. Facility staff in-serviced 4/24/19 on resident room door closure requirements by the SDC and Maintenance Director. Remaining facility staff to be re-educated by 6/3/19 by SDC.

4. Monitoring of corrective action to ensure the effectiveness of the education
 - A. Maintenance Director will review facility doors to ensure closure requirements are adhered to Monday thru Friday for 8 weeks (weekends reviewed Monday) and review findings with Safety Committee.
 - B. Findings will be reported to the, ED who will take appropriate action if needed.
 - C. Failure to adhere to facility requirement will result in re-education
 - D. Report of findings will be reported to the facility Quality Assurance Committee (QAPI) for a period of 8 weeks to review the need for continued intervention or amendment of plan- team includes: DON,ED, Dietary, Therapy, MDS, Housekeeping, Plant ops. (all department leaders)
5. COMPLETION DATE 6/3/2019

N 831 - 1200-8-6-.08 (1) Building Standards:

1. Corrective action(s) accomplished for those residents found to have been affected by the finding:
 - A. Fire barrier prevention in the following areas: Mechanical room across from housekeeping, mechanical room in kitchen, corridor wall between 209 and 211, corridor wall across from chapel, corridor wall between 608 and 610, above unit manager office, corridor wall over the soiled utility room 600 hall, corridor wall over 614, corridor wall at the 600 east stairwell, 2 hour fire barrier near 621, corridor wall above restroom next to room 621, corridor wall above room 622, above sign by room 625, elevator equipment room by maintenance – all areas corrected using approved fire caulking and barrier system by 5/8/19, completed by Maintenance staff.
2. Identify other residents who have the potential to be affected by the same finding and what corrective action taken:
 - A. Audit of facility fire barriers conducted by maintenance staff on 4/23/2019. No other areas identified in need of repair.
3. Measures/systematic changes put in place to ensure that the finding does not reoccur:
 - A. Maintenance staff in-serviced 4/24/19 on fire barrier maintenance by the Maintenance Director.

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45th day / 70th
6-8-19 / 7-3-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION POC#1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445512	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2019
NAME OF PROVIDER OR SUPPLIER NASHVILLE CENTER FOR REHABILITATION AND HEALING LL			STREET ADDRESS, CITY, STATE, ZIP CODE 832 WEDGEWOOD AVENUE NASHVILLE, TN 37203		
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K 000	INITIAL COMMENTS Stories: 1 (2 levels both at ground floor) Construction Type: NFPA, II (111) Plans available on site Constructed: 1970 Sprinklered: Yes Certified beds: 119 Census: 111 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 04/22/2019. During this Life Safety Survey, Nashville Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid with Title 42 CFR Subpart 483.70(a), The Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-06 Standards For Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition). During the survey, the fire extinguishers were labeled due for 6 year maintenance earlier in April during the annual inspection. Per the maintenance director, those extinguisher are scheduled to be replaced on the week of April 29th.	K 000			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to	K 211			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Administrator

(X6) DATE

5/9/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 211	Continued From page 1 full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the path of egress. This deficiency affects the lower level The findings include: Observation on 04/22/2019 at 10:16 AM, revealed pallets and 6" x 6" wood posts blocking the walk way outside the door by the dumpster. NFPA 101, 19.2.1 (2012 Edition), NFPA 101, 7.1.10.1 (2012 Edition) The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 04/22/2019.	K 211			
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324			

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K 324	Continued From page 2 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to maintain the cooking facility. The findings include: 1. Observation on 04/22/2019 at 12:02 PM, revealed the fryer was not centered under the hood suppression nozzle. NFPA 101, 19.3.2.5.1 (2012 Edition), NFPA 96, 12.1.2.2 (2011 Edition) 2. Observation on 04/22/2019 at 12:03 PM, revealed the fryer (on castors) was not tethered to the wall. NFPA 101, 19.5.1 (2012 Edition), NFPA 101, 9.1.1 (2012 Edition), NFPA 54, 9.6.1.1 (2012 Edition) The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 04/22/2019.	K 324			
K 353	Sprinkler System - Maintenance and Testing	K 353			

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K 353 SS=D	<p>Continued From page 3 CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the sprinkler system.</p> <p>The finding included:</p> <p>Observation on 04/22/2019 at 11:13 AM, reveled the kitchen walk in freezer sprinkler was not guarded from mechanical injury. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 6.2.8 (2010 Edition)</p> <p>The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 04/22/2019.</p>	K 353			

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K 521 SS=D	<p>HVAC CFR(s): NFPA 101</p> <p>HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to maintain the HVAC system.</p> <p>This deficiency affects all occupants.</p> <p>The finding included:</p> <p>Observation on 04/2/2019 between 9:00 AM and 9:56 AM, revealed no documentation for a fire/smoke damper inspection within the last 4 years. NFPA 101, 4.4.2.1 (2012 Edition), NFPA 101, 8.2.2.4 (2012 Edition), NFPA 80, 19.4.1.1 (2010 Edition)</p> <p>The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 04/22/2019.</p>	K 521			
K 741 SS=D	<p>Smoking Regulations CFR(s): NFPA 101</p> <p>Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:</p>	K 741			

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K 741	<p>Continued From page 5</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to enforce the smoking policy.</p> <p>The finding included:</p> <p>Observation on 04/22/2019 at 10:37 AM, revealed cigarette butts in the mulch outside of the maintenance office. NFPA 101, 19.7.4 (2012 Edition)</p> <p>The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on</p>	K 741			

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K 741	Continued From page 6 04/22/2019.	K 741			
K 761 SS=D	<p>Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101</p> <p>Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to maintain the fire doors.</p> <p>The findings include:</p> <p>1. Observation on 04/22/2019 at 10:53 AM, revealed the 3 hour fire/smoke wall entering the laundry area has over a 3/4 inch gap at the bottom of the door. NFPA 101, 19.7.6 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition), NFPA 80, 4.8.4.1 (2010 Edition)</p> <p>2. Observation on 04/22/2019 at 11:13 Am, revealed the kitchen storage room door wedged open. NFPA 101, 19.7.6 (2012 Edition), NFPA 101,</p>	K 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445512	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2019
NAME OF PROVIDER OR SUPPLIER NASHVILLE CENTER FOR REHABILITATION AND HEALING LL			STREET ADDRESS, CITY, STATE, ZIP CODE 832 WEDGEWOOD AVENUE NASHVILLE, TN 37203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 761	<p>Continued From page 7</p> <p>8.3.3.1 (2012 Edition), NFPA 80, 5.2.13.1 (2010 Edition)</p> <p>3. Observation on 04/22/2019 at 12:08 PM, revealed the therapy room door by room 626 has over a 3/4 inch gap at the bottom of the door. NFPA 101, 19.7.6 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition), NFPA 80, 4.8.4.1 (2010 Edition)</p> <p>4. Observation on 04/22/2019 at 12:53 PM, revealed the bed in RM 515 prevents the resident room door from shutting NFPA 101, 19.7.6 (2012 Edition), NFPA 101, 8.3.3.1 (2012 Edition), NFPA 80, 5.2.13.1 (2010 Edition)</p> <p>The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 04/22/2019.</p>	K 761			

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E 000	Initial Comments A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 04/22/2019. During this Emergency Preparedness Survey, Nashville Center for Rehabilitation and Healing was found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73.	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

5/9/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.